

patient reported outcomes as a measure of quality of clinician reported outcomes appears to be a feasible tactic in a site-based ratings surveillance quality assurance system.

**PMH64**

# **MAJOR DEPRESSIVE DISORDER: A COMPREHENSIVE LITERATURE REVIEW OF THE BURDEN OF ILLNESS IN NORTH AMERICA**

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**OBJECTIVE:** Major depressive disorder (MDD) is a leading cause of disability worldwide. This study analyzed the literature describing the burden of MDD in North America (USA and Canada), with particular focus on patients with treatment-resistant depression (TRD). **METHODS:** Systematic searches were conducted of English-language papers published between 1987 and 2007, utilizing MEDLINE, EMBASE, and the Cochrane Library, relevant websites, and hand searches. Major areas for review were the humanistic and economic burden of MDD. Additional areas for analysis included treatment options and costs, treatment efficacy and response rates, treatment guidelines, and reimbursements. **RESULTS:** A total of 908 articles were identified, of which 107 studies from North America fulfilled the inclusion criteria (humanistic burden, N = 45; economic burden, N = 49; and treatment guidelines, N = 13). Analysis of these studies identified an increased humanistic and economic burden in patients with MDD and TRD in North America. MDD was associated with a high prevalence (3–31%), was chronic in nature, and had a high frequency of comorbid mental disorders. Health-related quality of life (HRQL) instruments identified a significant negative impact from MDD, including domains of mental well-being (independence, alertness, role emotional, personal/spiritual beliefs) and perceived physical functioning (energy and fatigue, bodily care). In a study that compared HRQL in responders and non-responders to therapy, HRQL was significantly lower in non-responders ( $P < 0.001$ ). Patients with TRD were particularly severely affected, through higher medical costs and greater losses in work productivity. **CONCLUSION:** Patients with MDD and their families suffer greater humanistic and economic burden than healthy individuals. Treatment reduces the burden of MDD, although current evidence-based guidelines for MDD offer limited recommendations on the choice of pharmacological treatments based on their potential to reduce burden of illness and resource use.

## **MENTAL HEALTH—Health Care Use & Policy Studies**

**PMH65**

# **EFFECT OF PRIOR AUTHORIZATION ON ANTIPSYCHOTIC DRUG USE IN LONG-TERM CARE: POPULATION-BASED NATURAL EXPERIMENT**

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**OBJECTIVE:** Though antipsychotics were originally developed to treat schizophrenia, their use in older adults with dementia has grown substantially. Given concern about the safety of these drugs, we assessed the impact of a prior authorization (PA) policy

upon use and choice of antipsychotic medication in long-term care. **METHODS:** We conducted a retrospective cohort study using administrative data from two Canadian provinces—one in which access to newer antipsychotics (risperidone, olanzapine, and quetiapine) was unrestricted (Ontario), and another in which access required PA (British Columbia (BC)). Subjects were all 37,057 Ontario and 13,569 BC residents aged 66 years or older who were newly admitted to a nursing home between April 1, 1998 and March 31, 2002, who had no history of schizophrenia or psychosis in the 5 years preceding admission, and who had no evidence of antipsychotic drug use in the preceding year. We assessed crude and adjusted exposure to antipsychotic medication over the year following nursing home admission, as well as the types of medications used. **RESULTS:** Nineteen percent of Ontario residents were newly dispensed an antipsychotic within 100 days of nursing home admission vs. 16% in BC. Male sex, younger age, fewer comorbidities, and history of dementia all were strongly associated with receipt of an antipsychotic. Adjustment for these factors reduced the cross-provincial difference in drug use. However, fewer BC residents received newer antipsychotics, particularly after risperidone received an approved indication for the management of behavioural symptoms of dementia. Olanzapine, which required PA throughout the study, was dispensed to 11% and 3% of Ontario and BC residents, respectively. **CONCLUSION:** Although BC's PA policy had negligible impact upon the incidence of antipsychotic drug use as a whole, it appeared to influence drug choice. Questions remain about the impact of such policies upon health outcomes and costs.

**PMH66**

# **ETHNICITY AND THE IMPACT OF HIGHER MEDICATION COPAYMENTS AMONG VETERANS WITH SCHIZOPHRENIA**

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**OBJECTIVE:** The 2002 Veterans Health Care Act raised medication copayments from \$2 to \$7 for lower priority patients. Veterans with schizophrenia constitute a multiply disadvantaged population; 40% are antipsychotic non-adherent, substantially increasing psychiatric admission risks. Certain patient subgroups might be particularly sensitive to medication costs with significant clinical ramifications. Diverse cultural expressions of health beliefs and priorities contribute additional layers of complexity. This study examines potential inequities stemming from higher copayments. **METHODS:** All veterans with schizophrenia were followed 33 months Pre and Post copayment increase. Longitudinal models analyzed effects of higher medication costs in copayment veterans versus a natural control group of exempt patients, controlling for demographics, substance abuse, functional status, and other comorbidities. Adjusted means compared prescription patterns and inpatient utilization among four ethnic groups: white (N = 36,452), African-American (N = 17,602), Hispanic (N = 5,225), and Other (N = 10,707). **RESULTS:** African-Americans were relatively younger with higher substance abuse rates. Hispanic veterans were more likely to be unmarried and have multiple illnesses, though fewer (39%) faced copayments than other patients. Minorities filled 10–35% fewer prescriptions than white veterans, and ethnic differences were evident in pharmacy fills and inpatient days. White veterans reduced psychotropic fills 15% after the policy change, decreasing hospital days by nearly the same amount. However, minorities dropped psychotropics 19–22% while subsequently